DHS Oregon Department of Human Services

SHARED SERVICES
Office of Adult Abuse Prevention and Investigations

Oregon Health Authority

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CDDP
Abuse Investigation Report
REDACTED REPORT

CDDP Case Number:	55	**Investigator:**	Scott Christoferson
OAAPI Case Number:	DD170850	**County:**	Curry

Provider:	Mentor Oregon	**Provider Type:**	24 Hour Residential
Provider Address:			

Incident Date:	6/14/2017	**Incident Reported Date:**	10/4/2017	**Investigation Assigned Date:**	10/9/2017
Incident Location/Address:					

Alleged Victim Name	Address	Phone	DOB
AV	**XXX**	**XXX**	**XXX**

Alleged Perpetrator Name	Address	Phone	DOB	*Is AP*
[group home] (Mentor Oregon, Inc. / Curry County	**XXX**	**XXX**	**N/A**	☐ DHS Employee ☐ PSW
Bryan Hopkins	**XXX**	**XXX**	**XXX**	
Shelly Price	**XXX**	**XXX**	**XXX**	
Debra Griffith	**XXX**	**XXX**	**XXX**	
Laura Baumbach	**XXX**	**XXX**	**XXX**	
Dianna Wiles	**XXX**	**XXX**	**XXX**	

Alleged Abuse	Neglect	**AV:**	AV	**AP:**	[group home] (Mentor)	**Finding:**	Substantiated
Alleged Abuse	Neglect	**AV:**	AV	**AP:**	Bryan Hopkins	**Finding:**	Substantiated
Alleged Abuse	Neglect	**AV:**	AV	**AP:**	Shelly Price	**Finding:**	Substantiated
Alleged Abuse	Neglect	**AV:**	AV	**AP:**	Debra Griffith	**Finding:**	Substantiated
Alleged Abuse	Neglect	**AV:**	AV	**AP:**	Laura Baumbach	**Finding:**	Substantiated
Alleged Abuse	Neglect	**AV:**	AV	**AP:**	Dianna Wiles	**Finding:**	Substantiated

Allegation(s)

Allegation 1
It is alleged that Mentor Oregon neglected the care of Mentor resident AV resulting in hospitalization for medical treatment, in violation of ORS 430.735 (1)(e)(10)(c).

Allegation 2
It is alleged that Mentor Program Coordinator Bryan Hopkins neglected the care of Mentor resident AV resulting in hospitalization for medical treatment, in violation of ORS 430.735 (1)(e)(10)(c).

Allegation 3
It is alleged that previous Mentor Program Coordinator and now Program Director Debra Griffith neglected Mentor resident AV resulting in hospitalization for medical treatment, in violation of ORS 430.735 (1)(e)(10)(c).

Allegation 4
It is alleged that Vocational Center Coordinator and On-Call Weekend Manager Shelly Price neglected the care of Mentor resident AV resulting in hospitalization for medical treatment, in violation of ORS 430.735 (1)(e)(10)(c).

Allegation 5
It is alleged that Program Director Laura Baumbach neglected the care of Mentor resident AV resulting in hospitalization for medical treatment, in violation of ORS 430.735 (1)(e)(10)(c).

Allegation 6
It is alleged that Mentor Regional Administrator Dianna Wiles neglected the care of Mentor resident AV due to poor training and oversight of personnel resulting in a hospitalization for medical treatment, in violation of ORS 430.735 (1)(e)(10)(c).

Individuals Interviewed

XXX

Protective Services

☐ **Immediate Protection** ☐ **Assess Ability to Self-Protect/Give Consent.**
☐ **Understand and Accept Protective Services** ☐ **Verify Physical/Mental Status**
☐ **Alternate Living Arrangements** ☐ **Medical/Legal/Financial/Other** ☐ **Advocacy**
☒ **Consult with Provider/Program/Brokerage/Other.**

The CDDP required daily turn logs, progress reports and nurses notes must be turned into case manager and PSI Investigator (Exhibit 1). CDDP initiated a wound care plan for AV (Exhibit 2). AV ultimately left the [group home] and was immediately admitted to the hospital after AV was placed in AV's new [home].

Additional Information (site visit, investigation process, additional information)

Home Health Charts/Clinical Notes indicate a previous XXX dating 6/14/17 thru 8/1/17 (Exhibit 15). The CDDP was never notified of this incident, nor were any incident reports written by Mentor. XXX. I pulled OP1's medical monitoring review checklist and case notes (Exhibit 16) and there is no mention of bed sores until 8/29/17 when AV was denied by AV's insurance for a rojo cushion because there was no history of bedsores. This previous issue indicates a possible pattern of failing to report required information to the CDDP, and not making the proper reports when needed. This prior incident and information only came to light due to investigating this current investigation.

On 7/6/17 and 7/20/17 Home Health nurse showed up and Mentor [group home] did not have the ABD dressing on AV's Buttocks as per care plan in exhibit 15 page 2.

On 10/6/17 I went for a site visit and to get pictures of the XXX on AV (Exhibit 3). This home is nice and clean inside and out.

On 10/2/17 I received a referral from APS about AV indicating possible neglect concerns by AV's 24 hour residential home (Exhibit 4).

On 10/5/17, I received a SERT information Form (Exhibit 5) and an Incident report that was written on 10/5/17, although the alleged incident took place on or before 9/23/17 (Exhibit 6).

On 10/6/17, when interviewing AP2 I had AP2 pull any records that had mention of AV's sore on AV's bottom (Exhibit 7). AV's sore was first documented on 9/16/17 noting the sore was still present, indicating it had been present previous to this but with no documentation. There is also no documentation at all of turn logs due to the XXX until it was established as a protective services step required of Mentor.

Note: Turn logs are kept for the benefit of keeping a consumer continually moved so pressure is kept off of the bedsore allowing it to heal. By keeping these turn logs it would also support that Mentor was doing their job, but without documentation and the progression of the sore to the point it is a Stage 4 XXX, they (Mentor) have no way to prove any turns were being done.

On 10/9/17, I opened this in the SERT System as an investigation of neglect against Mentor [group home] (Exhibit 8). As the investigation proceeded, it became apparent that additional accused persons would be added.

Supporting Documents List

XXX

Investigation Summary

AV is a [age/gender] who resides in [group home] operated by Mentor Oregon. AV requires full support in all areas as AV is wheelchair/bedbound due to AV's diagnoses of XXX. AV must be handled with extreme care as AV also has XXX.

W1 stated new House Manager Hopkins told W1 AV has not been going to the vocational center due to

AV's XXX injury and during that time AV has developed a XXX. W1 stated when W1 looked at XXX and then showed another [person] the picture and they thought it could be a deep tissue wound.

W1 stated Hopkins told W1 he felt like AV was being neglected because the house is understaffed and he was not sure AV has been turned on a regular basis.

W1 stated that AV is susceptible to this kind of wound due to AV's diagnosis, but they have never had an issue this bad before. AV is also susceptible to this kind of wound due to the fact AV is wheelchair and bedbound.

W2 called 10/5/17 to make a report about AV being neglected and I informed W2 that it had already been called in. W2 stated W2 did not work in the house were AV lives but is friends with W5, and W5 informed W2 about the bedsore and how AV was not being taken care of as it looked infected.

W2 stated W2 informed that new manager Hopkins does not really know what he is doing as of yet. W2 stated that is all W2 knows, and it is second hand information so the interview was concluded.

On 10/4/17, I called Hopkins to set up an interview and asked him to have the turn log paperwork or any type of skin audits they have been doing to track XXX. Hopkins stated they have not been keeping any logs and have no paperwork to prove AV was turned, or is even being turned. Hopkins did not state why or if they have ever kept turning logs, but D. Griffith stated they do use turn logs and it was easy when using their old system Therap, but they have just switched to a new tracking system called IServe, which everybody has been trained on.

Hopkins stated he has been the manager at [group home] for approximately three weeks to a month. Hopkins stated he has been trained on all aspects of his duties by a combination of W6 (1 day), Debra Griffith (Griffith stated she did not train Hopkins) and Program Director Laura Baumbach. Hopkins did have some info on the sore on AV's buttocks, which was first documented on 9/16/17 as "bottom still has sore on it." [exhibit]

I asked Hopkins why they did not get AV to the doctor sooner and Hopkins stated that he thought they (he and his staff) could take care of the sore.

Hopkins stated that he had missed two medicine review appointments in which they were going to bring up the XXX. The appointment was missed because the electric ramp wasn't working on the van (It has a manual function as well) for the 9/20/17 appointment, and he forgot the 9/21/17 appointment with W4. Hopkins stated they did get AV in to see W4 on 9/27/17 and W4 ordered home health care which started on 10/2/17.

Hopkins stated they took AV to the Curry walk in clinic and then to Curry General Health Emergency room on 10/7/17 as XXX was not improving.

I asked Hopkins if he felt like AV had been neglected. He stated that AV probably has been due to being so short staffed and not being completely sure that his staff had been turning AV as required, or following his instructions.

D. Griffith stated her last day as [group home] Coordinator/Manager was the 9/15/17 and she took over as Program Director the following week.

D. Griffith stated AV was developing what looked like an XXX but it was just a red spot and was not broken open when she left the house. Shelly Price stated she did inform Laura Baumbach, the Program Director, and also the incoming house coordinator Hopkins. She stated she gave Hopkins W4's information and advised him to get ahold of W4 if it got worse like last time. (There was no documentation to prove or disprove this.)

D. Griffith stated AV had a previous bedsore in June, July, and August. D. Griffith stated she had got [health care] in for treatment and AV healed up and was released from needing [health care]. (The CDDP never received an incident report and the case manager was never informed of this until 28 days after AV was released from [health care].)

I asked D. Griffith why there was no turn logs or proper documentation for AV. D. Griffith stated that when they were using THERAP is was easy to track and now they have just got a new system ISERVE and the tracking is completely different and people need more training. D. Griffith stated she provided all of the training on ISERVE to all employees and Hopkins was in the training.

Price stated she is the Vocational Center Coordinator and was the on-call weekend manager for 9/23/17 and 9/24/17. Price stated W3 called her from [group home] and was concerned about AV's XXX and wanted her opinion on taking AV to the hospital/urgent care.

Price stated she went to the house and showed W3 how to turn AV and then left AV attends open and made like a tent over AV so the sore could breathe. Price stated she told W3 there was no reason to take AV to [clinic] as there was nothing they could do for AV. Price stated she did tell W3 if it was not better by tomorrow to inform the Program Coordinator and get to the doctor or call 911.

Mentor Regional Administrator Wiles stated she knew nothing about this incident until she was notified by OP1 on 10/3/17.

I asked Wiles if this matter involving AV's care by Mentor is a Mentor problem or a Bryan Hopkins problem. Wiles stated it was a Hopkins problem. Wiles stated she was going to be having a chat and sending Hopkins an email outlining his duties. Wiles did mention to me she was aware Hopkins had missed two medical appointments.

W3 stated W3 was working the weekend of 9/24/17 and when W3 went to change AV there were white specs of what looked like infection and AV's sore did not smell good.

W3 stated another consumer had come over after church to hang out with AV. W3 stated W3 showed W2 the sore on AV and W2 told W3 that looks really bad and AV needs to get to hospital.

W3 stated she called Program Coordinator Hopkins and he said not to worry about it. W3 stated W3 did notify the on-call weekend Program Coordinator Shelly Price who came over and helped turn AV, but said for W3 not to take AV to [clinic].

W3 further stated that Program Director Baumbach knew about the bed sore and said it wasn't necessary to go to hospital. I asked W3 if W3 was turning AV and W3 assured me that W3 was turning AV and had talked to Baumbach about it.

W5 stated W5 brought another consumer over to [group home] to hang out with AV after church on the 24th of Sept. W5 stated W3 showed W5 the XXX and it was "really bad". W5 stated W5 told W3 W3 needed to get AV to the hospital.

W5 stated W3 talked with House Manager Hopkins and he said something like, "They (hospital) won't do anything so no need to take AV." W5 further stated W3 called on-call weekend Coordinator Price and she came over to the house and turned AV and said AV did not need to go to the [clinic]. No photo on the 24th of Sept.

W5 stated W5 heard that W4 kept making doctor's appointments for AV and Brian would cancel or not show up.

W6 stated W6 worked with House Manager Hopkins one day on Sept 19th training him on things to do as a manager but was not familiar with the clients in the house or their needs. W6 stated it was just some basic paperwork training.

W6 stated W6 did not see AV's wound but W6 could smell the odor of bed sore/rotting flesh in the home.

W6 stated Hopkins did tell W6 how bad the sore was, and it was almost to the bone. W6 stated Hopkins said he was not sure that staff is doing the "Lotion & Potions" like they are supposed to.

I asked W6 how come W6 did not report anything and W6 stated that Hopkins had a Doctor's appointment for the next day so W6 was not concerned.

W6 stated that is all W6 knows as W6 works in Gold Beach and that is the only day W6 worked with him so I concluded the interview.

Baumbach, the Program Director for all of Mentor's group homes, stated she did not know of any sore on AV's bottom until the she received the email from Price, the on-call weekend manager. [exhibit] The email stated, "Sun, 9/24/17, W3 from [house] called at 12:13pm. W3 wanted me to come over and look at the skin breakdown on AV's rear end. I showed W3 how to turn AV all the way onto AV's side, while cushioning all AV's joints/shoulder/broken XXX. Two attends were put down and they were left completely open and flat, so AV's wound could get some air. AV was lightly covered with a tented pillow case for modesty since [consumer] was visiting from [house]".

Baumbach stated she ensured Hopkins got an appointment for AV to see AV's PCP and get Home Health assigned. Home Health did not show up for a week.

I asked Baumbach who was responsible to ensure that Hopkins was trained and Baumbach stated it was her responsibility.

W7 stated W7 had made two doctors' appointments for AV and Hopkins had missed both. When W7 tried to call and reschedule the doctor's office wanted to speak with Hopkins about making the appointments.

W7 stated everyone working with AV was aware of XXX and it was brought to Hopkins attention numerous times because it was getting worse and needing attention.

W7 stated W7 had mentioned going to the doctor and Hopkins had said no and Baumbach told W7 XXX was fine.

W7 stated Hopkins made the statement, "I can't wait for AV to move to the new house, AV is too much of a hassle."

W7 stated that you could smell the bedsore and that when W8 would come in, it would not smell for maybe thirty to forty minutes and then it would begin to smell quite badly again.

W8 stated this wound kind of looks like a deep tissue wound where blood accumulates under the skin and then it opens out. W8 stated W8 even brought in OP2 twice to look at AV's XXX. W8 stated they never directly told Mentor to go to the hospital because they had already taken AV to the Emergency room on 10/7/17 and care started on 10/2/17. W8 stated OP2 did mention that the only way this will heal is with surgical intervention to Program Coordinator Hopkins and a staff member.

W8 stated this is an unstageable wound.

W9 stated this XXX was worse than before when W9 first noticed the skin breakdown. W9 stated W9 was assured that AV was fine by Hopkins, Baumbach and Price, the weekend on call manager. W9 stated in W9's opinion all of the Direct Support Professionals working with AV are good workers, but just are doing as they are instructed by managers.

W9 stated when W7 came back to work on the 7th of October W7 was angry and took AV to Urgent Care in Brookings. Urgent Care staff stated XXX was beyond the scope of their work and AV would need to be transported to Curry General Hospital.

W10 stated W10 first noticed the sore on the bottom of AV on the evening of the 16th and morning of the 17th when working the graveyard shift. W10 stated W10 notified Hopkins when he came in that morning. W10 stated W10 also notified Baumbach, who told W10, "Oh really, OK, can you have Hopkins call me?"

W10 stated at first the sore was not a hole, but was just starting to breakdown and W10 noticed the smell of dead flesh. W10 stated W10 had a couple of days off then worked at a different house but when W10 came back to work at [group home] the sore was bigger and was definitely worse. W10 stated it was about the size of a 50 cent piece coin and W10 had a couple of gag moments when cleaning AV.

AIC Coordinator Wiseman asked W10 if by the reasonable person standard, would W10 think that AV was in significant pain. W10 stated yes and that they gave AV a suppository of Tylenol for pain as a PRN. W10 further stated W10 really does not feel comfortable giving the medication because it is so close to the open wound.

Follow-up interviews with Mentor Management on 10/21/17 at [group home]

Shelly Price - Vocational Program Coordinator and On-Call Weekend House Manager.

Price stated again she was called by W3 on 9/24/17 at 12:13 pm about taking AV to the hospital as the staff was concerned about AV's XXX.

Price stated on Sept 24th when she went to the home, the XXX was only about the size of a nickel. Price stated it was broken open, an irritated red color, and was moist but with no puss.

Price stated she showed the staff how to properly rotate AV and that she made like a bandage tent over AV so air could flow to help the sore. NOTE: According to Dr. Sheridan's email dated 04/30/18, making a tent with a bandage and allowing air to circulate around the wound to allow it to "breathe" is bad practice, as it allows for airborne bacteria, fungus, and viruses direct access to the open tissue, placing AV at greater risk for XXX growth and infection [exhibit].

Price stated she told staff not to take AV to Urgent Care because all they could do was put cream on the sore.

Price was asked if she had any medical knowledge and she stated she had a degree in Radiology and had worked in that field.

Price stated she did tell W3 if the sore is not better to let Program Coordinator/House Manager Hopkins know. Price stated this is Hopkins responsibility.

Price stated she did notify by email Program Director Baumbach and Area Administrator Wiles of the bedsore on 9/25/17 [exhibit].

Price was asked by the reasonable person standard if she thought AV was in pain at this time. Price stated AV has a PRN for that (XXX).

I showed Price the pictures of AV's bedsore and how it got progressively worse. Price stated it did not look like that when she saw AV on the 24th.

I asked Price if she neglected the care of AV resulting in hospitalization. Price stated, "I did not". I asked Price if in her opinion Mentor, as an agency, neglected AV and she stated "Yes."

Debra Griffith - Program Director for Gold Beach and Former [group home] Program Coordinator

Griffith stated her last day at the [group home] was the Sept 15th and at that point AV's sore was just a reddish spot like the start of a bedsore. (There was no documentation or incident report done before leaving the Program Coordinator position.)

I asked Griffith if she had trained Hopkins to be the Program Coordinator and she stated that was Baumbach's job. I asked Griffith if Baumbach had trained her when she took the position and Griffith stated she didn't get any training as she has been doing this for type of work forever.

I asked Griffith why there had been no incident report written up for the previous bedsore and she stated she didn't know she was supposed to.

I informed her that we never had any documentation of any bedsore until 8/29/17 when it was mentioned in OP1's [notes]. In OP1's XXX notes AV was denied by AV's insurance for a ROHO cushion as there is no history of bedsores.

I informed Griffith I have seen incident reports from Mentor for small things such as bruises and scrapes,

etc., and asked her how she could not know to make an incident report when a consumer is requiring medical attention. Griffith offered no answer.

I showed Griffith the pictures of AV's bedsore and how it got progressively worse. Griffith was visibly upset and offered no answer.

Griffith was asked to use a reasonable person standard and asked if she thought AV was in pain with the condition AV was in while at [group home]. Griffith stated, "Yes." Griffith added, "If I would have stayed at [group home] I don't feel like AV would be in the condition AV is in."

I asked D. Griffith if she felt like she had neglected AV. D. Griffith stated, "I do not feel like I intentionally neglected AV but when in the medical condition AV is in, I do feel bad and could have done more."

I asked D. Griffith if she felt like Mentor, as an agency, had neglected AV. D. Griffith stated, "I feel AV was neglected."

Laura Baumbach - Brookings Program Director.

Baumbach, who is the Program Director for all of group homes, stated she did not know of any sore on AV's bottom until the she received the e-mail from Price, the on call week-end manager on the 25th of Sept. This was 10 days after AV's sore was first noticed, and with a brand new program Coordinator in the house for 9 days.

I informed Baumbach that there had been many individual's interviewed that stated she knew of the sore before the 25th. Baumbach disagreed.

I asked Baumbach whose responsibility it is to train the house manager / program coordinators and Baumbach stated it was her responsibility.

I asked Baumbach why there had been no incident report or any documentation regarding AV's condition or turn logs until after Mentor was notified about this investigation of neglect. Baumbach offered no answer.

I showed her the incident report written after they had been notified of an investigation dated 10/5/17 which said, "The sore was healing remarkably well," with Baumbach's signature approving the document. I then showed her a picture of AV's sore from 10/2/17 and 10/6/17 and asked if that looked like it was healing remarkable well. Baumbach answered, "No."

I showed Baumbach the picture of AV's condition as AV arrived at the hospital in Corvallis [exhibit] after leaving Mentor's care at [group home]. Baumbach lowered her head and put her hands on her face.

I asked Baumbach if she had neglected the care of AV. Baumbach replied, "I did, as I failed to make sure of appropriated training."

I asked Baumbach if she felt Mentor, as an agency, had neglected AV. Baumbach stated, "I represent Mentor, so yes, AV was."

Dianna Wiles - Mentor Oregon Regional Administrator

I asked Wiles when was the first time she knew of the sore on AV's bottom. Wiles stated she did not know until OP1 told her about it on 09/25/17. I informed Wiles that was not possible as OP1 did not know until 10/2/17 when I informed her. Wiles was unsure of the date, but later sent an email [exhibit] which stated, "Hi Scott, The question of when I knew about the pressure sore date has been driving me crazy as the 25th sticks in my head, but so does the conversation with OP1. I went through my emails and I did find an email on the 25th that I responded to. So that must be why I kept saying the 25th. My memory of the conversation with OP1 was surrounding that a report of neglect had been made and the first indication that the pressure sore was that serious."

I asked Wiles what she had done to ensure AV's safety. Wiles stated she had directed Baumbach to oversee [group home] and the Program Coordinator Hopkins and she had spoken with Hopkins on two different occasions regarding his duties as a house manager.

I informed Wiles I had seen many staff in the past be put on administrative leave for far less significant allegations. I asked Wiles why she had not put Hopkins on administrative leave when he was under investigation when she knew Hopkins had made documentation mistakes and missed doctor's appointments for AV, and staff had made complaints about his leadership abilities. Wiles offered no answer.

I showed Wiles the pictures of AV's XXXs as they progressed while in Mentor's care, and explained the condition AV was in when arriving in Corvallis. Wiles did not offer a comment other than acknowledging how unfortunate the circumstances were.

I asked Wiles if she neglected AV by failing to provide instruction or oversite of her staff. Wiles replied, "I do not feel like I neglected AV."

I asked Wiles if she felt Mentor, as an agency, had neglected AV's care resulting in AV's hospitalization. Wiles stated, "In hindsight, we could have done things differently."

XXX Size Timeline according to staff, nurse notes and photo exhibits:

1. On 9/15/17 Program Director/Previous [group home] Debra Griffith stated there was a reddish area that looked like start of sore. Debra Griffith stated the sore was in the same spot on AV's bottom as before. This is when we found out there was a previous bedsore in June and July that was not reported to us at the CDDP.

2. On 9/16/17, W10 stated the sore was about the size of 50 cent piece and it was leaking fluid but had no smell when first noticed.

3. On 9/19/17, W6 stated W6 was in the home and you could smell an odor from AV's room. W6 stated W6 did not see the wound but Hopkins told W6 how much he was concerned and how bad the sore was getting "almost to bone."

4. On 9/24/17, Vocational Center Program Coordinator Shelly Price stated the sore was about the size of a nickel and had no puss coming from it. Price stated it looked like an "angry red color"

5. W3 stated W3 was working the weekend of 9/24/17 and when W3 went to change AV there were

what appeared to be white specs of infection and the sore did not smell good.

6. On 9/27/17, W4 stated W4 was seeing AV for AV 180 review and this is when W4 first new of this bedsore and initiated home health for a "threatening stage 2 XXX".

7. On 10/2/17 W1 took a picture of the sore [exhibit]. In notes it states, "Caregiver Bryan reports AV fell out of bed one month ago which resulted in XXX. AV has not been going to work vocational program as a result. AV developed skin breakdown, which caregiver states he feels was a "case of neglect", reports, "We've been understaffed" [exhibit]. W1 also stated in W1 notes under Plan/Orders Requested: "Skilled Nursing 2xweek for wound care, assessment and teaching. 4 PRN skilled nursing visits for falls, s/s infection, wound care, changes. Wound care: cleanse with wound cleanser, pat dry, sure prep with periwound skin. Cover with bordered foam sacral dressing. Change 2xweek and PRN. Facility may cleanse wound with wound cleanser if dressing becomes soiled or dislodged, then cover with large ABD" [exhibit].

8. On 10/6/17 I took two pictures during a home visit [exhibit]. I was doing a screening and interviewing the [group home] Coordinator Bryan Hopkins.

9. On 10/11/17, W8's notes state, "Wound on buttocks is deeper as necrotic sloth like tissue is reducing due to wound care" [exhibit].

10. On 10/12/17, W4 stated XXX was now a stage 3 or 4 XXX.

11. On 10/13/17, W8 states there is "a little discharge from around the catheter and reviewed catheter care and staff is to report if there is increased discharge or other changes". This catheter was put in place to help keep AV's XXX clean, as AV is incontinent [exhibit].

12. On 10/18/17, W8's notes state Hopkins declined todays visit to take care of AV due to no staff present.

13. On 10/17/17, W8's notes state "still has some grayish white slough like tissue on right side of wound with some tunneling on the left side" [exhibit].

14. On 10/20/17, W8's notes it states AV had a bowel movement and AV's dressing was soiled. OP3 reported to W8 OP3 has been told not to change the dressing but to call home health. W8's notes states "RN did contact PCP to report concerns of sore not healing" [exhibit]. OP3 stated there was a paper above AV's bed saying not to change AV and call home health. OP3 stated OP3 is not sure who put the paper up but was just following what the paper said.

15. On 10/20/17, OP2 notes states "XXX" [exhibit].

16. On 10/23/17, W8's notes states "AV showing signs of increased pain during care this visit". "Discussed possibly something stronger for pain management as patient is unable to express pain" [exhibit]. Staff continues to decline Home Health aide for education on catheter care and positioning.

17. On 10/23/17, 10/25/17, 10/27/17, 10/30/17 and 11/10/17 W8's notes state dressing was not in place when W8 arrived.

18. On 11/1/17, W8's notes state, "Staff feels that AV could be losing weight but do not have proper scale to weigh AV" [exhibit].

19. On 11/6/17, W8 notes state, "Has increased inner slough on inner left side of wound with 70% beef red. Has some undermining lower area of wound" [exhibit].

20. On 11/8/17, OP2 notes state, "Wound bed has 85% is slough that is gray and stool stained with a dusky appearance to the epithelial base". OP2 notes further stated, "Secondary to my inability to smell I don't know if the wound was odorous but I imagine there is an odor by the color of the wound bed and the drainage on the packing" [exhibit].

21. On 11/8/17, W8's notes stated, "Discussed wounds poor healing potential due to AV's physical status. AV looks very frail and extremities and face show signs of weight loss" [exhibit].

XXX Timeline for when Direct Support Staff, Program Coordinators, Program Director and Area Administrator knew of sore and who was notified.

1. 9/15/17, Program Director Debra Griffith stated on her last day as [group home] House Program Coordinator AV had a red spot like a bed sore starting. Program Director Debra Griffith stated she did inform Program Director Laura Baumbach of medical issues in the house before a new Program Coordinator Hopkins took over. There is no documentation of the sore and Laura Baumbach stated she knew nothing of the sore until 9/25/17 when notified by email by vocational Program Coordinator Shelly Price.

2. 9/16/17, W10 documented paperwork, "Sore still on bottom" [exhibit].

3. 9/19/17 W6 stated W6 did one day of paperwork training with incoming House Manager Hopkins on managing a house. W6 stated Hopkins mentioned the XXX to W6 and was seriously concerned. W6 stated you could smell an odor from AV's room but W6 did not worry about it because Hopkins was taking AV to the Doctor the next day.

4. 9/20/17 Bryan Hopkins House manager failed to get AV to AV's medical appointment. Appointment was for Medicine Review but they were going to have W4 look at the sore on AV's bottom.

5. 9/21/17 Bryan Hopkins House manager failed again to get AV to medical appointment. Appointment was for Medicine Review but they were going to have W4 look at the sore on her bottom.

6. 9/23/17 Documented paperwork from W10, "AV's bottom still looks same, no improvement".

7. 9/24/17 W3 called on call week-end coordinator Shelly Price about taking AV to the Emergency Room. Price stated she showed up and showed staff how to turn AV and made a tent like bandage out of blanket so the sore could breathe. Price told staff they did not need to take AV to Urgent Care because they wouldn't do anything but put cream on it.

8. 9/25/17 On Call Weekend Coordinator Shelly Price sent out an email notifying Laura Baumbach the Brookings Program Director, Debra Griffith Gold Beach Program Director, and Dianna, Wiles Regional Administrator [exhibit]. The email stated, "Sun, 9/24/17, W3 from [house] called at 12:13pm. W3 wanted me to come over and look at the skin breakdown on AV's rear end. I showed W3 how to turn AV all the

way onto AV's side, while cushioning all AV's joints/shoulder/XXX. Two attends were put down and they were left completely open and flat, so AV's wound could get some air. AV was lightly covered with a tented pillow case for modesty since [consumer] was visiting from [group home]".

9. 9/25/17 Baumbach stated this is when she first knew of the bedsore. Baumbach is in charge of all Houses and training for the house managers. The XXX was on AV for over ten days before Baumbach states she knew of the sore, with a brand new house manager that has only been on duty for ten days. It is her job to ensure Hopkins was trained properly and taking care of his job duties.

10. 9/27/17 Seen W4 for 180 med review/XXX and W4 ordered home health care for XXX.

11. 10/1/17, documented paperwork W10, "AV bottom did not smell as bad tonight as it did yesterday". [exhibit]

12. 10/2/17, W1 showed up to address the XXX per W4's orders and then called APS to report neglect, as the Program Coordinator Hopkins stated AV was being neglected due to understaffing and lack of care. Picture also taken of XXX by W1 on this date.

13. 10/6/17, I interviewed [group home] Coordinator Bryan Hopkins and got pictures of XXX on this date. These are the 2nd and 3rd pictures in [exhibit].

14. 10/6/17, An incident report was finally written by [group home] Coordinator Bryan Hopkins and approved by Program Director Laura Baumbach and turned into OP1 after Mentor was told they were under investigation. [exhibit] states, "The PCP ordered Home Health for AV. Since AV's visit and the arrival of Home Health, AV's bottom is making remarkable progress". Pictures of XXX around this time do not support what is being reported. This incident report was reported to OP5, OP6, Program Director Debra Griffith and Regional Administrator Dianna Wiles.

15. 10/7/17, AV was taken to Curry Medical center Walk in Clinic and seen by OP7. Staff was notified by OP7 that the extent of the injury was too extensive for their scope of care at a walk in clinic and AV would need a higher level of care. "The extent of the deep tissue injury is unknown at this time but it is suspected that all layers of soft tissue and possibly bone is involved" [exhibit]

16. 10/7/17 AV was taken to [hospital] by W7 on W7's own accord with no direction from management where AV was cared for and released (Approx. 6 hours in ER) [exhibit].

17. 10/12/17 AV was taken to W4 for checkup and W4 stated it was a stage 3 to 4 XXX per phone conversation.

18. 10/18/17, [group home] coordinator Hopkins declined Home Health Care due to no staff present at the [group home]. This information came from home health care charts/clinical notes [exhibit].

19. 11/3/17, Dianna Wiles, Mentor Area Administrator, stated to me she knew nothing about this matter until OP1 notified her about it on 10/3/17.

20. 11/9/17, W8 stated in W8's Physician Communication, XXX.

21. 11/13/14, Emergency ISP meeting including OP8, OP1, Mentor Area Administrator Dianna Wiles,

Program Director Laura Baumbach, Program Coordinator Bryan Hopkins and myself via phone conference to discuss AV's health concerns and moving AV to a medical fragile home with advanced care.

22. 11/14/14, Area Administrator Dianna Wiles removed Bryan Hopkins from his Program Coordinator role 6 weeks after he indicated possible neglect and short staffing in the house. Hopkins remained in the home as day shift Direct Support Staff.

23. 11/17/17 I notified OP9 of Brookings PD. OP9 stated to bring in my report and exhibits when I have finished with this investigation for law enforcement review.

24. 11/17/17 AV was moved to AV's new group home at [address].

25. 11/17/17 AV was immediately taken into the ER and admitted into Good Samaritan Hospital in Corvallis for the XXX. AV had surgery to remove the dead and decaying tissue and a Wound Vac was placed on the wound.

26. 11/28/17 I notified Oregon Nursing Board of Possible neglect. [email address]

Summary of Medical Records Information upon AV's Hospital Admission after Leaving Mentor's Care

1. 11/17/17, On [exhibit] Upon admission to Good Samaritan Hospital in Corvallis AV weighed 59lbs. During AV's last Adult Needs Assessment on 9/18/17 [exhibit] AV weighed 86 pounds. (Sore first documented 9/16/17). During this needs assessment 4 of the accused persons in this investigation were present.

2. 11/17/17, On [exhibit] it states, "XXX."

3. 11/17/17, On [exhibit] it states skin is warm and dry. "XXX" XXX.

4. 11/17/17, On [exhibit] it states, XXX

5. 11/17/17, On [exhibit] it states XXX

6. 11/17/17, [exhibit] it states XXX assessment. Uncertain if this is related to skin infection, dehydration secondary to poor oral intake.

7. 11/18/17 On [exhibit] on admission with XXX

XXX

8. 11/18/17, [exhibit] it states, XXX.

9. 11/18/17, On [exhibit] it states patient is being treated for XXX.

XXX

10. 11/18/17, On [exhibit] it states, "Patient with XXX".

XXX

11. 11/18/17, On [exhibit] it states, "Goals of care need to be established given the patient's age, medical comorbidities and malnourished state".

Comorbidity is the presence of one or more additional diseases or disorders co-occurring with a primary disease or disorder; in the countable sense of the term, comorbidity is each additional disorder or disease. The additional disorder may be a behavioral or mental disorder.

AV was not interviewed as AV is a non-verbal consumer

Home Health Charts/Clinical Notes indicate a previous XXX dating 6/14/17 thru 8/1/17 [exhibit]. The CDDP was never notified of this incident, nor were any incident reports written by Mentor. Debra Griffith was the [group home] Coordinator at that time. I pulled OP1 medical monitoring review checklist and case notes [exhibit] and there is no mention of bed sores until 8/29/17 when AV was denied by AV's insurance for a rojo cushion because there was no history of bedsores. This previous issue indicates a possible pattern of failing to report required information to the CDDP, and not making the proper reports when needed. This prior information only came to light due to this current investigation.

Forensic Medical Opinion

Dr. Daniel Sheridan is a Forensic Medical Consultant under contract with OAAPI to provide medical consultation and opinions on wounds and injuries such as AV's. Dr. Sheridan was asked to review all relevant documents and statements obtained in this investigation and provide his medical opinion as to whether the care, or lack of care, given to AV by Mentor and the above named individuals resulted in physical harm to AV. Dr. Sheridan provided a 22 page report regarding his assessment of this case (Exhibit 18), however, only the medical opinion is included in this report, which is as follows:

AV first developed pressure sores to AV's sacral region in early June 2017. Pressure sores in the Stage I and Stage II phases are extremely painful. By the time the sore reaches Stage III and Stage IV, the nerve endings in the skin and underlying tissues have died (become necrotic); thus, there is less pain in the center of the sore. However, there would continue to be pain to the outer edges of the Stage III and Stage IV sores and to the surrounding areas where there was still Stage I and Stage II skin damage.

AV did not have the ability to verbalize if AV were experiencing pain, however, in my opinion AV had to have been experiencing significant pain in June-July then again in September through November. In fact, the home health nurses made several entries in their notes that AV appeared to be experiencing pain, especially as the sore deteriorated. It was beyond the scope of what I was asked to review for this report, but in my opinion, AV's pain was under appreciated and under medicated by AV's direct care staff, home health nurses, PCP's and hospital health care staff because AV could not verbalize AV's pain level or readily physically communicate AV's pain secondary to AV's profound disabilities.

In June 2017, an appropriate referral for home health services was made and AV was first assessed by a registered nurse on 6-6-17. The home health notes I reviewed include numerous entries of the nurses training facility staff in skin breakdown prevention, pressure relief efforts, wound cleaning and wound care. In my opinion, all of these measures should have been immediately and permanently incorporated

into AV's individual service plan. Once a person develops a pressure sore, that person is always at high risk to develop additional pressure sores at the same location. This is especially true if the person has mobility challenges. In my opinion, failing to add skin breakdown prevention, pressure relief efforts, wound cleaning and wound care into AV's service plan placed AV at risk for physical harm and ultimately caused physical harm.

AV had known mobility challenges and it is my opinion, the facility should have developed a Turn Schedule in June 2017 to track reasonable efforts to minimize pressure AV's sacral region. I reviewed a Behavior Service Review dated 6-15-17 in which Debra Griffith signed she assisted in the review. I reviewed an ISP dated 7-20-17 in which Laura Baumbach signed that she assisted in the review. Neither of these reviews mentioned the fact that AV had a pressure sore and was receiving ongoing medical treatment from home health nurses and wound care from facility staff.

In my opinion, Griffith and Baumbach's failure to create a Turn Schedule placed AV at risk for physical harm which eventually resulted in physical harm. I reviewed a Medical Service Review completed and dated 8-29-17 by Griffith. This review documented AV had "bedsores" and under the column "Notes/Concerns/Need" she wrote "meds." Handwritten at the bottom of this form is a note whereby the PC (??) was working with the insurance company to obtain a Roho cushion.

In my opinion the Medical Service Review should have specifically outlined a plan of care to prevent future pressure sores to include the need for a Turn Schedule and a daily wound assessment form. In my opinion, Griffith failure to address these basic prevention activities, place AV at risk for and resulted in physical harm. I reviewed a Radiology Report dated 9-4-17 in which AV was diagnosed to have a XXX and another XXX from a reported fall 5 days earlier (on or about 8-30-17). The need for a Turn Schedule became more urgent when AV's mobility was severely compromised following the XXX.

In September 2017, when the facility staff first noticed a recurrence of possible skin breakdown to AV's sacral region, all care staff should have already been trained to review AV's service plan and find the wound care instructions from the pressure sores in June-July 2017. Namely, cleanse the area, ideally with MicroKlense and apply an ABD held in place by AV's briefs. In addition, the service plan should have included directions that the care staff immediately contact AV's PCP's with an update on AV's skin condition.

Instead, what happened is a non-medically trained direct caregiver (W10) on 9-17-17 documented AV's "...bottom still has a sore on it. I left the depend open to **let it breathe" (boldface emphasis mine)** (see Exhibit 7). On 9-21-17, W10 again documented, "...I put z guard on [AV's] bottom and alternated [AV] from back to left side and did not attach [AV's] attend together so [AV's] **wound could breathe**..." (see Exhibit 7).

On 9-25-17, Price sent an email to Bryan Hopkins, OP10, OP11, OP12, Laura Baumbach, Debra Griffith and Diana Wiles she was notified by W3 that AV had skin breakdown on AV's rear end. Price documented she rolled AV "all the way onto AV's side...two attends were put down and they were left completely open and flat, so AV's wound could get some air..." [exhibit].

In my opinion, the facility failed to adequately train all direct care staff to care for the skin to AV's sacral region with an antiseptic skin cleanser and the previously taught medical wound care plan used in June and July. In my opinion, this resulted in physical harm.

Griffith stated her last day as the [group home] Coordinator was 9-15-17 when she transitioned to the Program Director role at the Program. Based on W10's documentation on 9-17-17, AV had to have had a visible pressure sore before 9-15-17. In my opinion, while still in her role as [group home] Coordinator, Griffith failed to put in place a reasonable and immediate treatment plan that should have included appropriate immediate wound care, a medical evaluation by AV's PCP, requests for immediate home health nurses and notifications to her supervisors and to the county. In my opinion, this contributed to the physical harm AV experienced.

On 9-16-17, Hopkins became the [group home] Coordinator and received a 1-day orientation to the paperwork required for his new job by W6. In the records I reviewed, I did not read where he received any sort of change of leadership transition communication from Griffith or from Baumbach.

Baumbach reported she first became aware of AV's pressure sore on 9-25-17 when she received Price's email. In my opinion, this is an example of a serious systems problem whereby significant health changes of a vulnerable individual being served at one location within a multi-location agency were not being reported to the area director. In my opinion, Baumbach, in her role as the Brookings Program Director, did not have an administrative system in place whereby she would be informed in a timely manner of medical changes of the individuals at [group home]; allowed a poorly trained individual (Hopkins) to be the onsite Coordinator; then did not have in place a plan for him to receive more training on how to best serve the individuals in that home. After Baumbach was notified of AV's pressure sore, she failed to ensure this information was reported to Wiles, the Mentor Regional Administrator. In my opinion this contributed to the physical harm AV experienced.

Based on the information I was provided, Price reported to Wiles, the Mentor Regional Administrator. On 9-25-17, Wiles was notified of AV's pressure sore since she was included in the email sent by Price. However, when you interviewed Wiles, she stated she was not aware of AV's pressure sore until 10-3-17. In my opinion, Wiles failed to have in place a system whereby House Coordinators were adequately trained for the role and oriented to the unique needs of the individuals in [group home]. Wiles left Hopkins in the role as [group home] Coordinator for the remainder of September, all of October and the first few weeks of November 2017 while AV's physical condition deteriorated. In my opinion, this lack of administrator oversight and inaction contributed to the physical harm AV experienced.

AV had to have numerous daily dressing changes by facility staff for AV's pressure sores in June and July 2017 and again for AV's pressure sores in September through November 2017. Twice in only eight Clinical Notes I reviewed during the June-July 2017 care period and six times during the September – November care period the home health nurses arrived at the facility during the day shift to find AV did not have a dressing in AV's wound per the medical plan of care. In my opinion, this demonstrates an ongoing pattern of poor supervision by management.

The home health Clinical Notes repetitively documented the nurses, especially W8, were training and retraining the care staff for months. Based on my experience, the responsibility for ensuring all direct care staff follow medical orders rest with onsite supervisors, program administrators and area director. Failing to ensure AV was assigned care staff who knew how to care for AV's pressure sores, in my opinion, placed AV and risk for physical harm and contributed to physical harm.

The first mention in AV's facility care records that AV was having a recurrence of a pressure sore to AV's sacral region was on 9-17-17 from W8. However, AV did not have a medical evaluation until 9-27-17. Based on the wording of W10's note..."AV's bottom still has a sore on it...", facility staff were aware

AV had a sacral sore earlier than 9-17-17. From the records I reviewed, it has not been determined when or by whom it was first observed.

AV is incontinent of bowel and bladder and requires personal hygiene by care staff numerous times a day. In my opinion, when the first signs of a possible pressure sore were noticed, there needed to be an immediate notification of AV's primary care providers. Even when it was finally documented on 9-17-17, it took another 10 days for Camp to have a medical evaluation.

In my opinion, the onsite supervisor (Hopkins) failed to make prompt notification of AV's pressure sore thus directly contributed to physical harm.

On two occasions, Hopkins called and canceled scheduled Home Health Aide services designed to assess AV's pressure sore and to teach care staff wound care and positioning. In my opinion, when Hopkins failed to allow the HHA to perform [their] duties, it directly contributed to physical harm to AV.

Concerns of Missed Opportunities for Timely and Thorough Medical Care

AV was referred to the Curry Hospital ED on 10-7-17. AV was sent home after a 6-hour stay in the ED. Based on the state of AV's sacral pressure XXXs in the home health records, it is my opinion the medical care AV received in ED could have been more aggressive including a hospitalization for a further evaluation of AV's wound by infectious disease and surgical specialist. I base this opinion on my prior experiences as a home health nurse and ED nurse where patients with similar pressure sores without compounding disability issues would be readily admitted for a more in-depth evaluation. I would recommend this issue be explored further by practitioners with hospital admission privileges.

On 5-18-17, when W4 examined AV, W4 either missed or underappreciated the fact AV had lost 10 pounds in the year since AV's last an annual physical on 4-21-16. For most patients who have baseline weights well over 100 pounds and who tend to be above their ideal body weight, a 10-pound weight loss would not be medically significant. Generally, however, this level of weight loss would still be mentioned in the Progress Note. In addition, some of the afore-mentioned language in W4's progress notes about what staff reportedly told W4 about AV "slowing down" from the April 2016 and the May 2017 visits is so identical, it raises, in my opinion, concerns about the thoroughness, uniqueness and accuracy of W4's progress notes during these patient care encounters.

Further, when Hopkins brought AV to W4 on 9-17-17 I found no records that W4 obtained and documented AV's weight. AV was seen at the Good Samaritan Regional Medical Center ED on 10-12-17 and they documented AV's weight was 72 pounds. Based on the paucity of medical records from Curry Medical Center for me to review, I am not sure the ED actually took a weight or just recorded it from old medical records.

W4 saw AV again on 11-9-17 for an evaluation of AV's worsening pressure sore and a request by the care providers for nutritional supplements. Again, W4 failed to obtain and document AV's current weight. Eight days later, on 11-17-17, AV's weight at the Good Samaritan Regional Medical Center ED was 59 pounds, 8.4 ounces. This represents a 22-pound, 8.4-ounce weight loss since April 2017 and 12-pound, 8-ounce weight loss from October 2017.

It is beyond my scope of practice to evaluate the standard of care provided by a physician, physician assistant or nurse practitioner. However, in my opinion, there are numerous issues in the records I

reviewed regarding W4's care of AV that I am recommending W4 care of AV be peer-reviewed to determine if W4 was meeting a minimum standard of care; and if not, did W4's level of care cause physical harm to Camp.

In the months of October and November 2017, (W8) and the facility staff raised concerns that AV was continuing to lose weight, however, no one took responsibility to obtain an accurate weight. In my opinion, the facility needed to obtain for AV a wheelchair capable of recording an accurate weight. By failing to provide such a wheelchair, it is my opinion, it directly contributed to physical harm.

W8 was AV's xxx for the majority of AV's Skilled Nursing visits in June-July 2017 then again September through November 2017. W8 documented using wound care specialists and notifying W4 of changes to AV's wound condition. However, it is my opinion, W8 needed to be more assertive with AV's primary care providers in late October and November that AV's sores were worsening; and that AV needed an in-hospital evaluation. In addition, W8 is a mandated reporter of abuse and neglect. In my opinion, W8 had ample reasons to notify the county of possible neglect after only one or two of the times W8 found AV without a dressing in place. In my opinion, this borders on a failure to report by a mandated reporter and recommend the county review this.

Sincerely,
Daniel J. Sheridan, PhD, RN, FAAN
Forensic Nurse Consultant
(signed electronically 4-27-18)

Investigation Conclusion

ORS 430.735 (1)(e)(10)(c) defines Neglect as: "Abuse" means: Neglect. Withholding of services necessary to maintain the health and well-being of an adult that leads to physical harm of an adult.

Allegation 1

The allegation that Mentor Oregon House neglected the care of Mentor resident AV resulting in hospitalization for medical treatment, in violation of ORS 430.735 (1)(e)(10)(c), is Substantiated.

At the onset of this investigation, it was learned that information was withheld from the CDDP Case Manager by Mentor regarding a previous bedsore experienced by AV in generally the same area of AV's body during the summer of 2017. The CDDP was unaware of this incident until 3 months later when this investigation was opened. There were no incident reports written, and no documentation was provided to the CDDP regarding AV's prior condition.

A new sore appeared in September 2017 and was left unaddressed medically by new Program Coordinator Bryan Hopkins from the first notification of the sore on 9/16/17 until 9/27/17, when seen by W4 for AV's 180 med review. W4 ordered Home Health, but they did not arrive until 10/2/17 to treat AV's worsening XXX.

Mentor [group home] also did not have the proper scale to weigh and keep track of AV's weight. At the time of admission to the hospital in November 2017, AV had lost 22 lbs. between April of 2017 and

November 17, 2017. Medical records from AV's admission to the hospital after leaving Mentor in November indicate AV was XXX, weighing in at 59 pounds, and suffered from XXX.

Dr. Daniel Sheridan was asked to review all relevant information obtained in this investigation and provide an opinion as to whether Mentor's care, or lack of care, resulted in physical harm to AV.

In Dr. Sheridan's report he stated in his opinion, "The facility failed to adequately train all direct care staff to care for the skin to AV's Sacral Region". Dr. Sheridan also wrote, "In September 2017, when the facility staff first noticed a recurrence of possible skin breakdown to AV's sacral region, all care staff should have already been trained to review AV's service plan and find the wound care instructions from the pressure sores in June-July 2017. Namely, cleanse the area, ideally with [medicine] and apply an ABD held in place by AV's briefs. In addition, the service plan should have included directions that the care staff immediately contact AV's PCP's with an update on AV's skin condition."

Dr. Sheridan also commented on the pain AV was likely experiencing due to AV's lack of care by Mentor staff. AV's XXX started as a stage 1 bed sore, and progressed to stage 4 over roughly a two month period. Dr. Sheridan's report indicates AV very likely experienced significant pain during stages 1 and 2, and then as the sore progressed to stage 3 and 4, AV's nerve endings had died and had become necrotic in the center of XXX. However, according to Dr. Sheridan, AV likely still would have experienced significant pain around the edges of the sore. AV's pain management during this time was a PRN for [medicine], to be administered near the open wound.

There is a preponderance of evidence in this investigation to support the allegation that Mentor Oregon Park Place house neglected the care of AV resulting in physical harm to AV. Therefore, this allegation of neglect **is substantiated**.

Allegation 2

The allegation that Mentor Park Place Program Coordinator Bryan Hopkins neglected the care of Mentor resident AV resulting in hospitalization for medical treatment, in violation of ORS 430.735 (1)(e)(10)(c), is Substantiated.

After interviewing numerous witnesses and Hopkins, information obtained supports that Hopkins made significant errors regarding AV's medical care. Hopkins missed two doctor appointments for AV during the early stages of XXX on 9/20/17 and 9/21/17, to which AV's Home Health care could have been ordered and wound care could have been addressed sooner. Hopkins also stated to the Home Health nurse that he felt AV was being neglected due to the house being understaffed, and he was not sure that AV was being turned regularly. I asked Hopkins if there were any turn logs or skin audit being done and Hopkins stated there were no logs being kept.

Multiple staff expressed concerns about getting timely medical care for AV as AV's XXX worsened, but these concerns were either ignored or not taking seriously by Hopkins. Hopkins even called and canceled Home Health Aide services on several occasions, which according to Dr. Sheridan's report, directly contributed to the physical harm of AV. Hopkins was also heard telling staff he couldn't wait until AV was moved to a new home because AV was too much work to care for.

Hopkins was given this position as Program Coordinator at the [group home], and he was assigned this position with little to no training or oversight from Mentor management. However, evidence and

information obtained indicates Hopkins failed on numerous occasions, and over a significant amount of time, to provide adequate and timely medical care for AV, which resulted in AV being physically harmed. Therefore, the allegation of neglect against Bryan Hopkins **is substantiated**.

Allegation 3

The allegation that previous Mentor Program Coordinator and now Program Director Debra Griffith neglected Mentor resident AV resulting in hospitalization for medical treatment, in violation of ORS 430.735 (1)(e)(10)(c), **is Substantiated.**

During this investigation, information was obtained regarding a previous bedsore, which was AV's first bedsore ever, and started in June 2017 when Griffith was still Program Coordinator. The CDDP was never notified of any medical issues with AV at that time, nor was an Incident Report written. When asked why no incident reports were written regarding AV's first sore, Griffith stated that she did not know she had to report a bedsore.

Griffith stated her last day of work at [group home] was 9/15/17 and at that time AV had a small red spot on AV's bottom, like the start of a bedsore. Griffith stated she informed new Program Coordinator Bryan Hopkins and Program Director Laura Baumbach of the start of the sore on AV, however, there is no documentation to confirm this. When asked whose responsibility it is to train the Program Coordinators Griffith stated it was Baumbach's job. Griffith stated Baumbach never trained her, as she (Griffith) has been doing this type of work forever.

In his medical opinion, Dr. Sheridan wrote, "Griffith stated her last day as the [group home] Coordinator was 9-15-17 when she transitioned to the Program Director role at the Gold Beach Program. Based on W8's documentation on 9-17-17, AV had to have had a visible pressure sore before 9-15-17. In my opinion, while still in her role as [group home] Coordinator, Griffith failed to put in place a reasonable and immediate treatment plan that should have included appropriate immediate wound care, a medical evaluation by AV's PCP, requests for immediate home health nurses and notifications to her supervisors and to the county. In my opinion, this contributed to the physical harm AV experienced."

Referring back to the original bedsore during the summer of 2017, Dr. Sheridan wrote, "Also during this timeframe, when looking at the Home Health nurse notes, there were multiple times during Griffith's tenure as program coordinator that the nurse showed up and there was no dressing in AV's wound per medical plan of care which shows an ongoing pattern of poor supervision and management."

In Dr. Sheridan's medical opinion he wrote, "Once a person develops a pressure sore, that person is always at high risk to develop additional pressure sores at the same location." Dr. Sheridan also wrote, "In my opinion the Medical Service Review should have specifically outlined a plan of care to prevent future pressure sores to include the need for a Turn Schedule and a daily wound assessment form. In my opinion, Griffith's failure to address these basic prevention activities, placed AV at risk for and resulted in physical harm."

Dr. Sheridan also notes in his medical opinion, "I reviewed a Medical Service Review completed and dated 8-29-17 by Griffith. This review documented AV had "bedsores" and under the column "Notes/Concerns/Need" she wrote "meds." Handwritten at the bottom of this form is a note whereby the PC (??) was working with the insurance company to obtain a Roho cushion."

Based on the information obtained in this investigation, including the medical opinions of Dr. Sheridan, there is a preponderance of evidence to support the allegation that Griffith neglected the care of AV resulting in harm to AV. Therefore, the allegation of neglect against Griffith **is substantiated.**

Allegation 4

The allegation that Vocational Center Coordinator and On-Call Weekend Manager Shelly Price neglected the care of Mentor resident AV resulting in hospitalization for medical treatment, in violation of ORS 430.735 (1)(e)(10)(c), **is Substantiated.**

Price stated she is the Vocational Center Coordinator and was the on-call weekend manager for 9/23/17 and 9/24/17. Price stated W3 called her from [group home] and was concerned about AV's XXX and wanted her opinion on taking AV to the hospital or urgent care. Price stated she responded and showed W3 how to rotate AV and made a tent like bandage so air flow could get to the sore. However, according to Dr. Sheridan's email dated 04/30/18, this is not a good practice, as it allows for airborne bacteria, fungus, and viruses direct access to the open tissue, placing AV at greater risk for XXX growth and infection. Although Price only handled AV this one time providing direct support, she did not use proper technique treating the bedsore, and trained staff on the same incorrect practice. Dr. Sheridan wrote in his report, "In my opinion, the facility failed to adequately train all direct care staff to care for the skin to AV's sacral region with an antiseptic skin cleanser and the previously taught medical wound care plan used in June and July. In my opinion, this resulted in physical harm."

Price also told W3 there was no reason to take AV to urgent care at that time because there was nothing they could do for AV but put cream on the wound. When asked if Price has any medical expertise, Price indicated she has a degree in Radiology and had worked in that field. However, a degree in Radiology does not apply to assessing the need for XXX care, or in determining that taking AV to see a medical professional at that time would have served no purpose.

Price stated on Sept 24th when she went to the home, the XXX was only about the size of a nickel. Price stated it was broken open, an irritated red color, and was moist but with no puss. From the description of Price, it is clear there was an active and developing bedsore which had broken open, and both staff's W10 and W3 were expressing a need for medical care or concern for AV. Price failed to provide AV with timely medical attention at this time. The day prior, on 9/23/17, W10 of Mentor wrote in W10's notes, "AV's bottom still looks same, no improvement".

Price was asked if by the reasonable person standard if she thought AV was in pain at this time. Price stated AV has a PRN for that, a [medication], which would be applied in the region of XXX. According to Dr. Sheridan, stages 1 and 2 of a XXX can be extremely painful. Price's answer appears to indicate she gave little consideration to AV's level of pain at that time. Based on the preponderance of evidence obtained in this investigation, the allegation that Shelly Price neglected the care of AV resulting in physical harm **is substantiated.**

Allegation 5

The allegation that Program Director Laura Baumbach neglected the care of Mentor resident AV resulting in hospitalization for medical treatment, in violation of ORS 430.735 (1)(e)(10)(c), **is Substantiated.**

Baumbach, who is the Program Director for all of Mentor's group homes, stated she did not know of any sore on AV's bottom until the she received the e-mail from Price, the on call week-end manager, on 09/25. Baumbach stated it was her responsibility to train the house manager / program coordinators, in this case Bryan Hopkins. Previous Program Coordinator Griffith stated she was never trained by anyone, including Baumbach.

After reviewing the available information, Dr. Dan Sheridan offered his medical opinion. Dr. Sheridan wrote in his report, "In my opinion, Baumbach, in her role as the Program Director, did not have an administrative system in place whereby she would be informed in a timely manner of medical changes of the individuals at [group home]; allowed a poorly trained individual (Hopkins) to be the onsite Coordinator; then did not have in place a plan for him to receive more training on how to best serve the individuals in that home. After Baumbach was notified of AV's pressure sore, she failed to ensure this information was reported to Wiles, the Mentor Regional Administrator. In my opinion this contributed to the physical harm AV experienced."

Baumbach had no answer when asked why there was no incident report to the CDDP regarding AV's XXX until being notified about this investigation on 10/09/17. After receiving the incident report, Baumbach signed the document, which stated, "The sore was healing remarkably well." After showing Baumbach pictures of AV's XXXs from 10/2/17 and 10/6/17, and a picture of how AV arrived at the hospital in Corvallis, I asked her if this XXX looked like it was healing well. Baumbach answered "No" and put her hands over her face. Baumbach later stated she believes she neglected the care of AV, and added, "I did, as I failed to make sure of appropriated training."

Considering the information obtained, including Baumbach's own statements, as well as Dr. Sheridan's medical opinion regarding the role a lack of training played in this matter that resulted in medical harm to AV, there is a preponderance of evidence supporting the allegation that Baumbach's active or passive inaction was a contributing factor to the lack of care AC received resulting in physical harm to AV. Therefore, this allegation of neglect **is substantiated.**

Allegation 6

The allegation that Mentor Regional Administrator Dianna Wiles neglected the care of Mentor resident AV due to poor training and oversight of personnel resulting in a hospitalization for medical treatment, in violation of ORS 430.735 (1)(e)(10)(c), **is Substantiated.**

Based on the information provided, Price emailed several people, including Wiles, on 9-25-17. At this time Wiles was notified of AV's developing sore since she was included in the email sent by Price. However, when interviewed, Wiles she stated she was not aware of AV's pressure sore until 10-3-17.

When asked what she had done to ensure AV's safety, Wiles stated she had directed Baumbach to oversee [group home] and Program Coordinator Hopkins whom she had spoken with on two different occasions regarding his duties as a house manager. However, Wiles left Hopkins in the role as [group home] Coordinator for the remainder of September, all of October and the first few weeks of November 2017 while AV's physical condition significantly deteriorated. This lack of administrative oversight and inaction by Wiles contributed to the physical harm AV experienced by leaving AV in the care of Hopkins at [group home] as well as in the care of untrained staff ill prepared to deal with a medical condition of this severity. Staff frequently commented to Hopkins during this time that AV's wound smelled of rotting flesh, and Hopkins was told numerous times by staff that they were concerned for AV's wellbeing.

The home health Clinical Notes repetitively documented the nurses, especially W8, were training and retraining the care staff. The responsibility for ensuring all direct care staff follow medical orders rests with onsite supervisors, program administrators and ultimately the Area Director, Dianna Wiles. Failing to ensure AV was assigned a House Coordinator (Bryan Hopkins), and care staff who knew how to care for AV's pressure sores placed AV at risk for physical harm and contributed to physical harm. The fact that Wiles left House Coordinator Hopkins in his role for weeks after she became aware of this matter is beyond concerning. Wiles was aware of all the mistakes Hopkins was making in his role. Wiles stated she had spoken with Baumbach and Hopkins, but there was never any follow through to ensure Wiles' consumers were safe. Wiles ultimately is the one responsible for all consumers in the care of Mentor in Curry County.

All of Wiles' Managers stated they felt Mentor, as an agency, had neglected AV's care, including Wiles, indirectly:

I asked Price if in her opinion Mentor, as an agency, neglected AV and she stated "Yes."

I asked D. Griffith if she felt like Mentor, as an agency, had neglected AV. D. Griffith stated, "I feel AV was neglected."

I asked Baumbach if she felt Mentor, as an agency, had neglected AV. Baumbach stated, "I represent Mentor, so yes, AV was."

I asked Wiles if she felt Mentor, as an agency, had neglected AV's care resulting in AV's hospitalization. Wiles stated, "In hindsight, we could have done things differently."

The preponderance of evidence in this investigation supports the allegation that Wiles was aware of the ongoing situation involving AV as early as 09/25/17 and never intervened administratively with needed oversight, or took any corrective action steps to ensure AV received appropriate medical care from staff who are appropriately trained to provide that care. Based on the preponderance of evidence, the allegation of neglect against Dianna Wiles **is Substantiated.**

Recommended Actions

At the time of this report, ODDS will take steps to ensure safety of new placements in the Mentor program in Curry County.

AV was removed from the care of Mentor Oregon and placed in another adult foster home following AV's release from the hospital.

Additional actions are pending, and will be discussed when this report has been released to ODDS Licensing.

Report Distribution

OAAPI	Full Report (CDDP)	Redacted Report (CDDP)
☒ DD Licensing Unit-Full ☐ Medicaid Fraud-Full ☐ ODDS Provider Actions-Full ☐ Death: Health Management Specialist at DD County-Full ☒ OSBN-Full and Oregon Medical Board - Full ☒ Alleged Perpetrator-Substantiated/ Redacted Report	☒ LEA – Brookings Police Dept. ☐	☒ Brokerage/CDDP ☒ Provider ☒ OAAPI - Substantiated

Notice of Outcome (CDDP)	Department Specific Notice
☒ Alleged Victim ☐ Alleged Perpetrator (Not Substantiated/Closed without Abuse Determination) ☐ Reporter – if requested ☒ Guardian ☐	☐ DHS HR ☐ PSW Notification ☐

Investigator Name Printed:	Scott Christoferson		
Investigator Signature:		**Date:**	5/1/2018
Approving Supervisor Name Printed:	Matthew Clark		
Approving Supervisor Signature:		**Date:**	5/1/2018
Abuse Investigation Coordinator Name Printed:	Eric Wiseman, OAAPI AIC		
Abuse Investigation Coordinator Signature:		**Date:**	5/4/2018